EDMOND G. BROWN JR., Attorney General
of the State of California
MARETTA WARD, State Bar No. 176470
Deputy Attorney General
California Department of Justice
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-1384
Facsimile: (415) 703-5480

Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CHARLES ELLIS TURNER** **aka KING ELLIS TURNER** Post Office Box 282244 San Francisco, California 94128 4 Captain Drive # 6207 Emeryville, California 94606 Registered Nurse License No. 540158 Respondent.	Case No. 2008-104 **A C C U S A T I O N**

Ruth Ann Terry, M.P.H., R.N., Executive Officer ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

License History

2. On or about January 30, 1998, the Board issued Registered Nurse License Number 540158 ("license") to CHARLES ELLIS TURNER, also known as KING ELLIS

TURNER ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on October 31, 2007, unless renewed.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with Code section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 118, subdivision (b), provides that the suspension, expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

6. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

7. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter, it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing

with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

8. Code section 4060 states, in pertinent part:

No person shall possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, . . . or furnished pursuant to a drug order issued by a certified nurse-midwife . . . , a nurse practitioner . . . , or a physician assistant. . . .

9. Health and Safety Code Section 11173, subdivision (a), provides that no person shall obtain or attempt to obtain controlled substances, or procure or attempt to procure the administration of or prescription for controlled substances, (1) by fraud, deceit, misrepresentation, or subterfuge; or (2) by the concealment of a material fact.

REGULATION

10. California Code of Regulations, title 16, section 1442, states:

As used in Code section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

COST RECOVERY

11. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

12. **DRUGS**

"Dilaudid" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(K).

///

"Morphine (MS)" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(M).

"Fentanyl" is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (c)(8).

FIRST CAUSE FOR DISCIPLINE

(Obtained and Possessed Controlled Substances)

13. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that between approximately October 10, 2002, and November 7, 2002, while on duty as a registered nurse at Stanford University Medical Center, Emergency Department, in Stanford, California, Respondent committed the following acts:

a. Respondent obtained Dilaudid, Morphine, and Fentanyl, all controlled substances, by fraud, deceit, misrepresentation or subterfuge by obtaining the drugs from hospital supplies, in violation of Health and Safety Code section 11173, subdivision (a).

b. Respondent possessed unknown quantities of Dilaudid, Morphine, and Fentanyl, all controlled substances, without a valid prescription, in violation of Code section 4060.

SECOND CAUSE FOR DISCIPLINE

(Incorrect and/or Inconsistent Entries in Hospital and/or Patient Records)

14. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that between October 10, 2002 and November 7, 2002, while on duty as a registered nurse at Stanford University Medical Center, Emergency Department, in Stanford, California, Respondent made grossly incorrect or grossly inconsistent entries in hospital and/or patient records in the following respects:

Patient A

a. On October 12, 2002, at 0206 hours, Respondent withdrew one 2 mg/1 ml. ampule of Dilaudid, a controlled substance, from the Pyxis machine for this patient.

At 0245 hours, Respondent charted the administration of 1 mg. of Dilaudid in the Emergency Department Nursing Record; however, Respondent failed to chart the wastage or otherwise account for the disposition of the remaining 1 mg. of Dilaudid in any patient or hospital record.

Patient B

b. On October 15, 2002, at 0147 hours, Respondent withdrew one 2 mg/1 ml. ampule of Dilaudid, a controlled substance, from the Pyxis machine for this patient. However, the physician's order was for 1 mg. of Dilaudid. At 0351 hours, Respondent charted the wastage of 2 mgs. of Dilaudid, over two hours later, which was witnessed by a staff member.

Patient C

c. On October 20, 2002, at 0213 hours, Respondent withdrew one 2 mg/1 ml. ampule of Dilaudid, a controlled substance, from the Pyxis machine when there was no physician's order for Dilaudid for this patient. Respondent failed to chart the administration, wastage or otherwise account for disposition of the 2 mgs. of Dilaudid in any patient or hospital record.

Patient D

d. On October 23, 2002, at 2321 hours, Respondent withdrew one 100 mcg/2 ml. ampule of Fentanyl, a controlled substance, from the Pyxis machine when there was no physician's order for the Fentanyl for this patient. Respondent failed to chart the administration, wastage or otherwise account for the disposition of the 100 mcgs. of Fentanyl in any patient or hospital record.

Patient F

e. On November 1, 2002, at 2329 hours, Respondent withdrew one 100 mcg/2 ml. ampule of Fentanyl, a controlled substance, from the Pyxis machine for this patient. At 2330 hours, Respondent charted the wastage of the 100 mcgs. of Fentanyl, which was witnessed by a staff member. However, at 2320 and 2325, Respondent charted the administration of an unintelligible amount of Fentanyl in the Emergency Department Nursing Record as being administered to this patient.

///

Patient G

f. On November 2, 2002, at 2115 hours, Respondent withdrew one 100 mcg/2 ml. ampule of Fentanyl, a controlled substance, from the Pyxis machine when the physician's order was for .75 mcg. of Fentanyl for this patient. At a time prior to the withdrawal of the Fentanyl, at 2100 hours, Respondent charted the administration of .75 mcgs. of Fentanyl in the Emergency Department Nursing Record. However, Respondent failed to account for the disposition of the remaining .25 mcgs. of Fentanyl in any patient or hospital record.

g. On November 3, 2002, at 0032 hours, Respondent withdrew one 10 mg/1 ml. syringe of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. At 2135 hours, Respondent charted the administration of 6 mgs. of Morphine Sulfate in the Emergency Department Nursing Record. However, at 0032 hours, the Pyxis machine indicates Respondent wasted 8 mgs. of Morphine Sulfate, which was witnessed by another staff member.

Patient H

h. On November 3, 2002, at 2144 hours, Respondent withdrew one 2 mg/1 ml. ampule of Dilaudid, a controlled substance, from the Pyxis machine for this patient when there were no physician's order for the Dilaudid. At 2344 hours, Respondent charted in the Emergency Department Nursing Record that the patient was discharged from the Emergency Room. On November 4, 2002, at 0100 hours, Respondent charted the wastage of the 2 mg/1 ml.ampule of Dilaudid, over 3 hours later, which was witnessed by a staff member.

Patient I

i. On November 4, 2002, at 0004 hours, Respondent withdrew one 2 mg/1 ml. ampule of Dilaudid, a controlled substance, from the Pyxis machine for this patient. At 2315 and 2380 hours, Respondent charted the administration in the Emergency Department Nursing record an unintelligible amount of Dialudid given to this patient. At 0005 hours, the Pyxis machine indicates Respondent wasted 1 mg. of Dilaudid and the amount administered as none. Furthermore, Respondent failed to chart the wastage or otherwise account for the disposition of the remaining 1 mg. of Dilaudid in any patient or hospital record.

Patient J

j. On November 7, 2002, at 0731 hours, Respondent withdrew one 4 mg/1 ml. syringe of Morphine Sulfate, a controlled substance, from the Pyxis machine when the physician's order was for 2 mgs. of Morphine Sulfate for this patient. At 0730 hours, Respondent charted the administration of 4 mgs. of Morphine Sulfate in the Emergency Department Nursing Record for this patient.

Patient K

k. On November 5, 2002, at 0146 hours, Respondent withdrew one 100 mcg/2 ml. ampule of Fentanyl, a controlled substance from the Pyxis machine. At 0200 hours, Respondent charted the administration of .50 mcgs. of Fentanyl in the Emergency Department Nursing Record for this patient. At 0200 hours, the Pyxis machine indicates Respondent wasted .50 mcgs. of Fentanyl which was witnessed by a staff member. Again at 0238 hours, Respondent withdrew one 100 mcg/2m. ampule of Fentanyl and at 0238 hours, he charted the administration of .50 mcgs. of Fentanyl in the Emergency Department Nursing Record for this patient. At 0246 hours, the Pyxis machine indicates Respondent wasted .50 mcgs. of Fentanyl which was witnessed by a staff member. Respondent was not assigned to this patient.

Patient L

l. On November 4, 2002, at 0325 hours, Respondent withdrew one 4 mg/1 ml. syringe of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. Respondent charted the administration of 2 mgs. of Morphine Sulfate each time at 0240 and 0255 hours in the Emergency Department Nursing Record. However, the charted times were prior to the withdrawal of the drug.

Patient M

m. On October 14, 2002, at 2101 hours, Respondent withdrew one 10 mg/1 ml. syringe of Morphine Sulfate, a controlled substance, from the Pyxis machine when there were no physician's order for the Morphine Sulfate for this patient. At 2140 hours, Respondent charted the administration of 4 mgs. of Morphine Sulfate in the Emergency

Department Nursing Record. However, Respondent failed to account for the disposition of the remaining 6 mgs. of Morphine Sulfate in any patient or hospital record. Furthermore, Respondent was not assigned to this patient.

Patient N

n. On October 21, 2002, at 0410 hours, Respondent withdrew one 10 mg/1 ml. vial of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient when the physician's order was for 2-4 mgs. of Morphine Sulfate. Respondent charted the administration of 2 mgs. of Morphine Sulfate at an unintelligible time and charted another 2 mgs. of Morphine Sulfate at 0430 hours in the Emergency Department Nursing Record for this patient. However, Respondent failed to account for the disposition of the remaining 6 mgs. of Morphine Sulfate in any patient or hospital record.

Patient O

o. On November 6, 2002, at 2129 hours, Respondent withdrew one 100 mcg/2 ml. ampule of Fentanyl, a controlled substance, from the Pyxis machine when Respondent was not assigned to this patient. Respondent failed to chart the administration or wastage or otherwise account for the disposition of the 100 mcgs. of Fentanyl in any patient or hospital record.

Patient P

p. On October 10, 2002, at 0027 hours, Respondent withdrew 4 mgs/1 ml. syringe of Morphine Sulfate, a controlled substance, from the Pyxis machine when Respondent was not assigned to this patient. The physician's order was for 2 mg. of Morphine Sulfate and was tagged "hold" for this patient. Furthermore, Respondent failed to chart the administration or wastage or otherwise account for the disposition of the 4 mgs. of Morphine Sulfate in any patient or hospital record.

q. On October 10, 2002, at 0027 hours, Respondent withdrew one 100 mcg/2 ml. ampule of Fentanyl, a controlled substance, from the Pyxis machine when Respondent was not assigned to this patient. Furthermore, Respondent failed to chart the

///

administration or wastage or otherwise account for the disposition of the 100 mcgs. of Fentanyl in any patient or hospital record.

Patient Q

r. On October 12, 2002, at 0753 hours, Respondent withdrew one 100 mcg/2 ml. ampule of Fentanyl, a controlled substance, from the Pyxis machine when Respondent was not assigned to this patient. Furthermore, there were no physician's orders for the Fentanyl. Respondent failed to chart the administration or wastage or otherwise account for the disposition of the 100 mcgs. of Fentanyl in any patient or hospital record.

Patient R

s. On October 20, 2002, at 2318 hours, Respondent withdrew two 10 mg/1 ml. syringe of Morphine Sulfate, a controlled substance, from the Pyxis machine for this patient. The next day, at 0430 hours, the Pyxis machine indicates Respondent wasted 8 mgs. of the Morphine Sulfate, which was witnessed by a staff member. However Respondent failed to account for the disposition of the remaining 2 mgs. of Morphine Sulfate in any patient or hospital record.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence)

15. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, as defined in California Code of Regulations, title 16, section 1442, in that between October 10, 2002, and November 7, 2002, while employed at Stanford University Medical Center in Stanford, California, Respondent committed acts constituting gross negligence, as set forth in paragraphs 13 and 14, above.

///

///

///

///

///

///

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 540158 issued to CHARLES ELLIS TURNER, also known as KING ELLIS TURNER;

2. Ordering CHARLES ELLIS TURNER, also known as KING ELLIS TURNER, to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 9/25/07

Elliot Hochberg for
RUTH ANN TERRY, M.P.H., R.N.
EXECUTIVE OFFICER
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

SF2005200264
10217092.wpd